Ministry of Health

National Health Service

The Administrative Structure of the Medical and Related Services in England and Wales

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CONTENTS

ADMINISTRATIVE STRUCTURE OF THE MEDICAL AND RELATED SERVICES IN ENGLAND AND WALES

FOREWORD

The Aims and Nature of the Green Paper

In November, 1967 I announced that I was making a careful examination of the administrative structure of the medical and related services for which I am responsible. In this Green Paper I put forward some tentative proposals for England and Wales as a basis for wide public discussion and consultation with representative bodies. The Secretary of State for Scotland is carrying out a separate review of the structure of the National Health Service in Scotland.

In announcing my review, I commented that it had been wise to avoid making too early adjustments in the structure of the National Health Service which came into operation in 1948. It was a framework well suited to the immediate needs, in particular to the reorganisation of hospital and specialist services. That phase, however, is past. It seems that the organisation of medical and related services, in the community and in the hospitals, has now progressed almost as far as is possible within the present divided administrative structure. The response to my announcement showed widespread recognition that the time has come for that structure as a whole to be radically reconsidered.

The proposals in this Green Paper for a new administrative structure are entirely tentative. The unusual form of publication, as a Green Paper, emphasises the Government's belief that the question of long term reorganisation in the health services is one to which the opinions of those interested and involved in the future of this great enterprise should contribute. No decisions will therefore be taken by the Government until representatives of the authorities concerned and of those providing the medical and related services have been consulted and proper account has been taken of their views. Thought will also have to be given to other services which are the concern of other Government Departments but which are closely related to those for which I am responsible at the Ministry of Health. Moreover, any conclusions on the future organisation of health services must take account of the recommendations of the Seebohm Committee on the Local Authority and Allied Personal Social Services[1] and of the Royal Commission on Local Government in England. The Report of the Royal Commission on Medical Education[2] is also relevant.

The paramount requirement is that all the different kinds of care and treatment that an individual may need at different times, whether separately or in combination, should be readily available to him. This requires the closest collaboration between the doctors, nurses and other workers who give him their help. It also requires close collaboration between those who provide and administer the various services to which all these workers belong. The importance of this collaboration is widely acknowledged and I know of many suggestions—at conferences, and in reports and articles—for the best means of furthering it. The discussions I have had with the Long Term Study Group, whom I invited in July, 1965 to help me with broad surveys of the future, have also helped me to

(1) Cmnd. 3703. H.M.S.O., July, 1968.
(2) Cmnd. 3569. H.M.S.O., April, 1968.

formulate my proposals. As a result of all these things I have decided that the central theme of this Green Paper must he the unified administration of the medical and related services in an area by one authority, in place of the multiplicity of autborities concerned in the present arrangements.

Great advantages would flow from this unification of administration, whatever the preeise form of the area authority may be. One form whieh will fall to be considered is that in each area a new type of local authority, sueh as may be created after the Royal Commission on Local Government has reported, might itself constitute a suitable eommittee for this purpose.

It would not be appropriate to try to antieipate, in detailed diseussion in this Green Paper, the effect of changes which might result from the Royal Commission's Report. But it must be recognised that a unified administration of health services under local authorities would raise major issues in relation to financing the integrated services, and one should certainly bear in mind the aeknowledged difficulties of increasing local revenues and the problem of reconciling the continuing independence of local government with eontinuing and increased support from the Exchequer; sueh issues would call for extensive further consideration. Another form to be considered is that special new local boards might be set up responsible directly to tbe Minister. In order to illustrate as elearly as possible what these new bodies—called "Area Boards"—would involve this Green Paper sets out to give, in Chapter 3, the kind of details on whieh discussion would be helpful. But let me make it elear that this is simply as a basis for discussion and does not imply that any decisions have been reached as between this form of area authority and any other.

Whatever principles are finally deeided upon for tbe reorganisation of the medical and related services, special consideration will bave to be given to their application in Wales taking account among other faetors of the stage reaehed in the evolution of Welsh local authorities.

I wish also to emphasise that if, after discussion, the decision is to make ehanges in the administrative structure, and to promote legislation wbether ou the lines here described or otherwise, the representatives of the staff will be fully consulted before the changes are put into force.

To sum up, my aim is to reach a elear view, based on full debate, of what administrative structure will best fit these vital national services in England and Wales for the ehallenges of the 1970s and 1980s. There has been widespread discussion of this snhject for several years. This Green Paper is intended to focus the debate as the time for important and far reaehing decisions draws near.

KENNETH ROBINSON

Minister of Health

CHAPTER 1

THE NEED FOR CHANGE

EXISTING ADMINISTRATIVE STRUCTURE

1. The promotion of a comprehensive health service was the principal aim of the legislation which established the National Health Service. The pattern of local administration introduced for this purpose has remained virtually unaltered since 1948. Similarly the administration of the welfare services for which the Minister is responsible was settled in 1948. The broad features of the structure may be briefly stated.

Hospitals

2. Hospital authorities are numerous. The higher management, on behalf of the Minister, is in the hands of 14 Regional Hospital Boards in England and a Hospital Board in Wales. Day to day management and control is with 330 Hospital Management Committees. The management of teaching hospitals is separately vested, under the Minister, in 36 Board of Governors, 26 of which are in London. Appointments to Hospital Boards are made by the Minister; Management Committees are appointed by the Regional Boards.

Health Services in the Community

3. Health care in the local community is a divided responsibility. Medical care is for the most part provided by family doctors. These doctors, as well as dentists, opticians and pharmacists, are in contract with Executive Councils. The members of the 134 Councils are appointed by the Minister, by the local health authorities and by the professions.

4. The 175 local health authorities[1] provide general supportive services. These cover medical, dental and other services for mothers and young children in ante-natal, post-natal and child health clinics; domiciliary midwifery; home nursing and health visiting; vaccination and immunisation; home helps; the ambulance service; services for the mentally ill and the mentally handicapped including training centres and hostels; family planning; health education; the provision of nursing items; recuperative care; chiropody; and other measures for the prevention of illness, or the care and after-care of those who are ill. Many local authorities have health centres at which by arrangement with Executive Councils and Hospital Boards a range of services are provided. Some services are provided by arrangement with voluntary organisations.

Welfare Services

5. Local anthorities provide welfare services under the National Assistance Act, 1948.[1] These consist of residential services for the elderly, infirm and handicapped, temporary accommodation for the homeless and welfare services for the elderly and handicapped. Many of those who need these social services also need the services of doctors, nurses and other health workers, though perhaps only from time to time. A variety of administrative arrangements exist; in most

(1) Local health and welfare authorities are the county councils, county borough councils, the London borough councils, and the Common Council of the City of London. Some 30 borough and district councils also carry out certain personal health and welfare functions by delegation. Borough and district councils also have welfare functions in providing meals and recreation for old people. In London, the ambulance service is a function of the Greater London Council.

authorities there is a separate welfare committee and chief welfare officer; in about one third there are joint health and welfare committees, though in some of these the departmental organisation is separate.

Other Services

6. Local authorities have other functions, perhaps less personal but no less important and requiring medical and related professional skills. These functions include food hygiene and the prevention of spread of infectious diseases (mainly functions of county borough and district councils) and the registration of nurseries, of nursing homes, and of homes for the disabled, the elderly and the mentally disordered (carried out by county and county borough councils). Certain authorities are responsible for health control at seaports and others at airports.

The "Tripartite" Structure

7. The three main groups of services—under Executive Councils, hospital authorities and local authorities—are often referred to as the "tripartite" structure, but this is a simplification. Hospital authorities themselves are of three kinds and their interrelations are complex. The major local authorities are both local health authorities and local welfare authorities, and some important health functions are carried out by other local authorities. There are two systems of finance: the hospital and Executive Council services are financed (apart from receipts from charges) from taxes and the National Health Service contribution; the local authority health and welfare service on the other hand are paid for (again apart from receipts from charges) from rates, though with substantial Exchequer help through the rate support grant. The numbers and size of the main authorities are given below[1].

(1)

Regional Hospital Boards (and Welsh Hospital Board)			
Population:	under 2 million	3	
	2–3 million	3	
	3–4 million	5	
	over 4 million	4	
		—	15
Board of Governors of Teaching Hospitals			36
Hospital Management Committees			
Beds:	1– 500	33	
	501–1,000	83	
	1,001–1,500	86	
	1,501–2,000	69	
	over 2,000	59	
		—	330
Local Health Authorities*			
Population:	1– 75,000	25	
	75,001–150,000	44	
	150,001–500,000	83	
	500,001–1 million	17	
	over 1 million	6	
		—	175
Local Authorities* with Welfare Functions under the National Assistance Act			
As for local health authorities.			
Executive Councils			
Population:	1– 75,000	22	
	75,001–150,000	37	
	150,001–500,000	48	
	500,001–1 million	17	
	over 1 million	10	
		—	134
			690

* Excludes authorities with delegated functions.

Present Performance and Future Challenge

8. Within the framework laid down by the existing legislation services have been developed and strengthened and new patterns of care introduced. In the general medical services group practice has been considerably extended and in many places there is now a confident move towards practice from health centres. Local authorities are steadily developing and improving their health services, though over the country as a whole the published development plans of local authorities show wide variations between different areas in standards of service, both actual and planned. A major achievement of the planning of the hospital service has been to provide specialist care more evenly over the country, with improved facilities and the building up, and better location, of specialist staffs. A very large programme of hospital renewal—one of the largest building programmes in the whole public sector—is now under way, and its results are increasingly evident; by the 1970s annual expenditure on new hospital building should be well above £100 million. This momentum needs to be maintained in all three branches of the services.

9. Within the "tripartite" structure the authorities seek to co-ordinate the provision of services. Hospitals, with their elaborate and expensive clinical facilities, are most effectively planned and used if full account is taken of the other health and welfare facilities and of the plans for developing them. The value of area planning is increasingly understood. The association of local authority staff with general medical practice is rapidly extending. In some places there are novel schemes requiring close co-operation; for example, area plans are being drawn up for several New Town and similar developments.

10. The increasing efforts devoted to trying to secure proper collaboration, and the obstacles to their success, are both evidence that the administrative structure itself may be inadequate to meet new challenges. Although it has allowed high standards of service to be achieved and maintained locally, the present signs of stress seem likely to grow.

11. The number of separate authorities in the present administrative structure is nearly 700. They vary widely in size, resources, opportunity and scope. Moreover the different types of authority draw on different sources of funds and this delays and complicates attempts to co-ordinate services. There are different relationships between the Ministry, on the one hand, and the local authorities, the Executive Councils and the hospital authorities on the other. The development of the hospitals as a national service has led to an increasing demand by the hospital authorities themselves for guidance from the Department on general principles, but this has often proved difficult to formulate in terms of a divided service. Consultation and co-ordination between separate local administrative bodies, however willing, is bound to be time consuming and the effort may be disproportionate to the return.

12. Nor are the respective rôles of Regional Hospital Boards and Hospital Management Committees sufficiently clear. The problems of staffing a national hospital service with over 350 employing authorities are formidable. Also, the interest which Regional Hospital Boards have increasingly taken in the performance of management functions by Hospital Management Committees, though not outside their statutory powers, may go beyond what was envisaged when the

structure was established. Their primary task as originally conceived was planning and co-ordinating development; their intervention in matters of management has grown out of their responsihility for allocating financial resources, hut is sometimes unwelcome. Confused responsihilities tend to create unsatisfactory relationships.

13. The next two decades will offer great challenges. The task of achieving good standards of service in all areas must be pressed forward. At the same time the patterns of care must be continuously adapted to advances in medical, nursing and scientific methods. The services throughout the country must be alert to create and exploit new opportunities in treatment and prevention. The large resources of capital and skilled manpower involved need to be organised and managed with high efficiency at all levels. The hroad national policies and priorities need to cover the whole field of medical and related services; it would appear that they could he better drawn and hetter carried out if those locally responsihle were themselves dealing with a wide range of services and were not confined to planning for one part of the field only.

14. It is particularly important to employ the men and women in all parts of the service wisely and well, without duplication of tasks and without confusion of function. Staff for highly specialised work must not he wastefully dispersed.

15. All this calls for foresight and planning, as well as day to day management, of a high order. It would seem right that those making plans for the future and those managing the present arrangements should he more closely linked. A highly dispersed administration appears less well fitted to achieve the objectives with the resources availahle than would he a smaller numher of strongly staffed management authorities. Wide areas and considerable population are desirahle as the basis for effective and continuing studies of need and for improving the use of resources hoth in the development of staffs and the planning of accommodation and facilities. "Statistical and other sources of information now delineate the community's need in depth and detail never possihle hefore. This sharper perception of prohlems of planning and of evaluation of medical care services demands a higher efficiency than that of which the existing machinery is capable."(1)

16. The present administrative structure is not adapted to meeting those exacting requirements. It limits the range of those responsihle for planning future progress to their own segment of the service. Again, some of the hospital regions are perhaps too large; the hospital management groups, on the other hand, are more or less limited to day to day work and their catchments seldom coincide with the areas of the local health authorities or the Executive Councils. In evaluating and improving methods of care those professionally responsihle may often be ready to cross or even ignore, as far as they can, the existing administrative boundaries. But this is not enough. The structure ought positively to encourage more integrated services and patterns of care. The present structure inhihits this and is widely regarded within the service as hoth frustrating and uneconomical. Resources are not used as effectively as they could be, and this is especially true of staff. In his Annual Report for 1966, a year which he called a "turning point", the Chief Medical Officer outlined some recent improvements in medical services and their organisation. He wrote:

(1) First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals, paragraph 73. H.M.S.O., 1967.

"The changes we need are beginning to occur on a considerable scale, largely unheralded and as a result of spontaneous local action. But they could proceed much more quickly if we chose our methods and deliberately deployed our resources to this end. Money is needed for this, but more money spent in the old way is not the answer. Manpower is more limiting than lack of money, and efficient use of what we have is essential."[1]

17. This opinion appears to be widely shared among those working in all quarters of the services. Many are not happy with their present "terms of reference" and would welcome the opportunities which a new administrative structure would offer.

(1) On the State of the Public Health, p.3. H.M.S.O., 1967.

CHAPTER 2

THE SCOPE OF NEW AUTHORITIES

A Single Authority for Medical and Related Services in each Area

18. In the light of what has been said, it is believed that a new administrative structure is required. The authorities of the future should have wide scope to bring together the related services and plan boldly for new patterns of care. A further aim should be a drastic reduction in the number of administrative units. The new bodies should bear the direct responsibility for using resources, including manpower, efficiently and effectively. They should deal with the needs of fairly large areas and dispose of substantial blocks of resources to meet them. They should combine the management and evaluation of today's work with the planning and preparation of tomorrow's.

19. The central government must necessarily have an important guiding rôle; but it should not attempt itself to undertake the tasks of management in the field. Indeed, the Ministry of Health's rôle should be to formulate and state the broad strategy, to define the goals and to see that resources of all kinds are fairly allotted and common policies and priorities pursued in the interest of the whole community. Without this framework, local administration would lack the necessary direction and purpose. Tactical execution of these strategies would, however, be a local task; and if it is to be done well, the responsibility for administering comprehensive services in each area should lie squarely upon an area authority.

20. It is therefore proposed that there should be a single authority in each area and that these area authorities should replace and undertake the functions of the Executive Councils, Regional Hospital Boards, Boards of Governors and Hospital Management Committees, and, as discussed below, should be responsible for some important functions now in the hands of the present local authorities. This chapter examines the possible scope of such an organisation, and it will, of course, be understood from the foreword to this Green Paper that references to establishing new area authorities for the medical and related services do not imply what form the new authorities might take.

THE MAIN FUNCTIONS OF AREA AUTHORITIES

Comprehensive Care

21. The principal object in setting up a new area authority for health services would be to give it comprehensive scope for co-ordinating the policy and operation of a wide range of services; for planning the efficient use of complementary resources; and for striking the right balance between care in the community and hospital care. The extent of the area authority's functions is now discussed.

Services at Present Administered by Executive Councils

22. The advantages that would follow the administration of these services by a new comprehensive authority are outlined in paragraphs 33 to 37.

Hospital and Specialist Services

23. The new area authority might appropriately carry out functions similar to those of all the existing hospital authorities, subject to points discussed later in

this Green Paper. Thus there would be a single tier of administration for all hospitals in the health service, less remote from the individual hospitals than the present Regional Hospital Boards. The existing division of administrative responsibility for, on the one hand, day to day control, and, on the other, major planning, would come to an end.

Community and Other Local Health Services

24. The community health services at present provided by the major local authorities need to be considered together with the hospital and general practitioner services. The next six paragraphs discuss arguments in favour of the new area authority undertaking these community health services. There are however also links, and a continuing need for close collaboration, between local health services and other local services in particular those concerned with public health, environmental services, and social care which are discussed in later paragraphs. The arguments in favour of a fully unified administration of the health services must therefore be looked at alongside the need for co-ordination over a wider field, and in the light of the recommendations of the Seebohm Committee and of the Royal Commission on Local Government in England. The aim should be to reduce the problem of co-ordination of different services to the smallest practicable dimensions and to arrange that the geographical areas of administration of the health services, if not the same as, coincide as far as possible with any new local government areas.

25. Taking the main branches of care in turn, firstly, home nursing and health visiting and other health services which the present local health authorities provide for the prevention of illness, care and after-care require increasingly to be provided alongside and in close association with general medical care by the family doctor. These services, together with the establishment of health centres, could appropriately be the responsibility of the new area authority.

26. Secondly, the pattern of maternity care is changing and there is an urgent need to organise comprehensive services which take into account the high proportion of hospital confinements and the possibilities of earlier discharge from hospital. The domiciliary midwifery services, with their close connections both with the general practitioner and with the hospital maternity and specialist services, would also naturally fall to be administered by the new area authority.

27. Thirdly, the report of the Sheldon Committee[1] refers to the "continuing need for a preventive service to safeguard the health of children" and expresses the view that in the long term this "Child Health Service" will be part of a family health service provided by family doctors working in groups from purpose-built family health centres. At the same time the Committee has advised that the organisation of the Child Health Service calls for a highly trained medical administrator. If the present local health authority services for mothers and young children become part of a comprehensive service administered by a new area authority, this would provide a good framework for implementing the recommendations of the Committee.

28. Fourthly, the organisation and management of the health care of the long-term sick, including disabled persons requiring medical and nursing care, and of the elderly and the mentally disordered is at present the responsibility of

(1) Report of Sub-Committee on Child Welfare Centres p.35. H.M.S.O., 1967.

general practitioners, hospital authorities and local health authorities. In total these patients require the services of a very substantial proportion of the available staffs, both in hospitals and in the community. The effective development of comprehensive services for them requires that all aspects of their health care should be the responsibility of a single authority and this would be among the new area authority's most challenging tasks.

29. Fifthly, programmes of vaccination and immunisation, and the organisation of family planning clinics and of health education require to be closely integrated with the services already mentioned and developed alongside them.

30. Finally, the chief task of the ambulance service is to carry patients to and from hospital, mainly for pre-arranged routine journeys. To bring this service under an area authority which would also be responsible for the planning and management of the hospitals, might be expected to result in a closer operational relationship between these services and so secure the most effective use and disposition of ambulances.

31. When these considerations are taken together there is clearly a very strong case for the new area authority to take responsibility for all the health functions of the present local health authorities. This would enable the personal health services now given by general practitioners and by doctors working in public health departments to be improved by integration—a process already started, but requiring to be developed faster. It would promote the organisation of effective teams, with supporting staff, to provide services based upon group practice and upon health centres.

32. Medical Officers of Health would then be able, as officers of the area authority, to extend their rôle as community physicians—specialists in community medicine. Their duties would include the epidemiological evaluation of the standards of health in each area. The need for this work is becoming more and more obvious, and it might best be developed and put to its fullest use if care in the community and in hospital were provided by a single authority. The inclusion of responsibilities for the prevention of communicable disease and for environmental hygiene would complement and strengthen this side of the authority's work, and is considered later (in paragraphs 43–48).

General Medical and Dental Practice and the Ophthalmic and Pharmaceutical Services

33. If new area authorities replaced Executive Councils, they would be able to enter into contracts with medical and dental practitioners, pharmacists and opticians for the provision of general medical, general dental, general ophthalmic and pharmaceutical services. The setting up of new area authorities need not of itself involve changes in the terms of contracts or in the procedure by which they are at present negotiated and determined. Structural changes of this kind would not have any bearing on the method and level of remuneration, nor would there be any question of giving the new authorities power which would trench upon the contractor's individual clinical independence.

34. A change to a new area authority would not imply a material change as regards professional committees, representing the medical and dental practitioners, opticians and pharmacists, which, reshaped to cover each new area, could be given the same statutory recognition as now and be formally consulted

hy the new area authorities as they are hy the present Executive Councils. Nor need any change be involved in the rôle of Service Committees which enquire into questions relating to a contractor's compliance with his terms of service.

35. A change in local administration need not affect the relevant central authorities, such as the National Health Service Trihunal. The Dental Estimates Board could continue to regulate matters relating to the treatment of dental patients and the remuneration of dentists, and the pricing of prescriptions could continue to be carried out hy a body corresponding to the present Joint Pricing Committee. No change would be implied in tbe work of the Medical Practices Committee which could continue to receive information periodically from the new area authorities to enahle it to judge the adequacy of medical services in practice areas, and to have regard to this in carrying out its functions in relation to the distrihution of doctors.

36. If new comprehensive authorities replaced Executive Councils, more thought could be given than is at present possihle to the orderly development of the general medical services in relation to tbe other services. This would give the family doctor greater scope to play his part within the health services. He would be in contract with the authority responsihle for the other community care services and for the hospitals, with both of which he is in daily touch; a formal administrative link would supplement and improve the existing operational liaison. This would make it easier to arrange and carry through arrangements for mutual support. Forexample, the new area authorities would be able to promote schemes, where these do not yet exist, for the association of health visitors, home nurses and others with general medical practices, and would also be responsible for health centres. This new comhination of responsibilities should result in a better balanced service, in which community facilities, including the family doctor service, and the hospitals would be developed with regard for each other's needs and capacities and would provide for continuity of care. It would he right for the Minister to use his general strategic oversight to guide development towards securing the best balance between all areas and all activities without impairing local responsihility. The new arrangements would also have to ensure that the individual general practitioner would have all the support he needed by way of the provision of facilities for his work, without in any way interfering with his responsihility for his own patients.

37. Another valuahle feature of the new arrangements would be that the new authorities would encourage co-operation between their other services and those provided by dentists, opticians and pharmacists. For example, those aspects of dental work which are of special priority—the treatment of expectant and nursing mothers and of children—would require authorities to co-ordinate the general dental services, the hospital dental services and those dental services which are at present provided by local health authorities all of which would appropriately become functions of the area authorities.

Clinical Teaching, Postgraduate Medical Education
Specialised Services and Research

38. No organisation for comprehensive health services would work satisfactorily unless it were closely integrated with provision for clinical teaching, for postgraduate medical education and for specialised services. Research too must be carried out into many aspects of the community, domiciliary and hospital

services, bearing in mind that basic medical research is primarily the responsibility of the Universities and the Medical Research Council and that the rôle of the Ministry and the National Health Service is complementary.

39. Postgraduate medical education has in recent years been promoted by the setting up of a regional organisation to supervise it locally and by the establishment of postgraduate education centres for doctors and other professional staff. Future arrangements for their development will require joint action by the Universities, the professional colleges and the Government and the recommendations of the Royal Commission on Medical Education are at present being considered.

40. Clinical teaching and research are carried out both in hospitals at present managed by Hospital Management Committees under Regional Hospital Boards, and more particularly in hospitals designated by the Minister as "teaching hospitals" and managed by Boards of Governors responsible directly to him(1). The teaching hospitals form an essential part of the health service by providing both local district services and some forms of specialised treatment over a wider area; by conducting research and development; and by bearing responsibility for training many grades of staff required throughout the service. There are thus very strong reasons for including them within the main pattern of administration, so that their general and specialised resources can be planned to the best advantage and integrated with the rest of the service. These hospitals are of great importance, both regionally and nationally, and stand in a special relation to the Universities. Provided appropriate arrangements were made in respect of this, they would be suitably placed under the responsibility of the new area authority in whose area they are located.

41. In accordance with the new authority's area plans teaching (or university) hospitals would play their part in the provision of medical and related care in their districts, in close association with the community services. At the same time their specialised services would be available to meet requirements for a wide area, in some cases stretching far beyond the immediate area served by the authority. Arrangements would have to be made between authorities and in collaboration with Universities to co-ordinate the provision of specialised facilities required over several areas, and to provide authorities with advice on clinical research.

42. Arrangements would also be needed for postgraduate medical education. These might take the form of a postgraduate education committee with strong representation from the university and the professional colleges, as well as representation from each of the several area authorities concerned, which would be in a position to guide the development of postgraduate medical education and its integration with the needs of the service.

PUBLIC HEALTH

43. Close links between the personal health services and certain aspects of public health work are essential to prevent and control communicable disease. Responsibilities should be clear so that there is continuous and effective

(1) A further category of "university hospital" is provided for in the Health Services and Public Health Bill.

surveillance in the community of the incidence of communicable disease, and of the safety and cleanliness of foods; and so that suspicious circumstances are promptly investigated, skilful and thorough medical assessments made, and firm measures taken to prevent, limit and control the spread of disease.

44. The drawing of the precise dividing line between the public health functions of a new area authority and the related functions of local authorities would have to await decisions on the future organisation of local government. Any proposals would then need to be discussed in detail between the various authorities, the professional and other bodies, and the Government Departments concerned.

45. If the area authorities were felt to be the appropriate means of deploying in a single organisation all the medical and related skills involved in public health activity, the doctors concerned would be well placed to work in close collaboration with general practitioners and hospitals, and also with the Public Health Laboratory Service. They would require supporting staff, who might include public health inspectors, and would need to be able to take any necessary action on behalf of their authority in good time, and have suitable legal powers to do so, including authority to mobilise assistance in dealing with any serious outbreaks.

Environmental Services

46. It is also important to have proper links between the medical and the environmental services such as water supply, refuse disposal, sewerage, clean air, housing and prevention of nuisances. The appropriate officers of the new area authority might have a specific duty to give advice on the medical aspects to the local authorities and other bodies concerned; and the local authorities and other bodies a corresponding duty to seek it, and to provide any information and assistance required for this purpose. This would make it unnecessary for the authorities responsible for environmental services to employ their own medical staff, and would achieve economy of medical manpower. The responsibilities of the new area authorities, local authorities and others for the exchange of information would of course need to be defined.

47. If the responsibilities of the new area authorities suggested in the two preceding paragraphs were coupled with responsibilities for community health functions as described in paragraphs 25–32, the present functions and powers of Medical Officers of Health would be wholly concentrated within the new organisation and they would have the opportunity to develop their important rôle, and the skills of their staff, in this wider framework.

Port Health

48. The primary object of a health service at seaports and airports is to prevent the importation of dangerous infectious diseases or unsafe food into the country. Local responsibility for this service could therefore appropriately be placed on the new area authorities. Their officers would undertake inspection of imported food for possible danger to health, and they would also carry out the medical examination of immigrants. In London, and elsewhere if the need arose, a single port health authority might cover the areas of more than one of the new authorities.

Other Medical and Related Services

49. It would be for consideration whether the new authorities should become responsible locally for any other medical and related services, besides those mentioned.

Voluntary Services

50. The new area authorities, like the local authorities today, would make arrangements with voluntary organisations and give them financial and other assistance for the provision and promotion of services within the general scope of the authorities' responsibilities. There would still be ample opportunity for voluntary effort and Leagues of Friends and similar groups could extend their activities to support the full range of the comprehensive services.

Social Care

51. No review of the administrative structure required for medical and related services could be complete which did not take account of the social work services also. It is true that different considerations apply to the provision and organisation of the two groups of services, but it is also true that in varying degrees according to the service concerned they need to be planned and operated in close association with each other.

52. These problems are of crucial importance; it would, however, be premature to seek to resolve them at the present stage. Tbe nature of their solution must turn on the recommendations of the Seebohm Committee and of the Royal Commission on Local Government no less than on the consideration of the proposals made in this Green Paper.

CHAPTER 3

ASPECTS OF ORGANISATION

AREA BOARDS

Introduction

53. This chapter describes what the arrangements might be if the new area authorities were to be specially constituted Area Boards,[1] responsible directly to the Minister. It is necessary to describe this possihility in some detail so that it may be examined and discussed. As stated in the foreword, however, this does not imply that any conclusion has been reached between this possibility and any others such as the establishment in each area of a suitably constituted committee of the new type of local authority that may be estahlished when the recommendations of the Royal Commission on Local Government have been received and considered. In the latter case the arrangements would depend, among other things, on the form of local government itself, although many of the principles embodied in the suggested detail of Area Boards, aimed at securing the integration of the comprehensive services, might still be appropriate—for example those mentioned in paragraph 60.

Number of Area Boards

54. In discussing the number of specially constituted Area Boards that would be required in England and Wales there are several factors to take into account. Each Board should have full scope for the efficient and imaginative development of comprehensive services. Each must be able to employ the expert skills necessary for their planning and operation. Each should be sufficiently removed from day to day operations to take a wide view of their efficiency and requirements, and to allow the professional staff and officers who manage units of the service to get on with their jobs. An Area should also group together a number of localities each of which should be large enough to provide a reasonahle, natural and coherent working frame for the usual range of community health and general practitioner services, and contain its own focus of hospital services at a district general hospital (or several hospitals jointly providing this service for the locality). These considerations suggest that each Board should cover quite a large area and serve a substantial population, and that the total number of Boards should not be large—perhaps about forty or fifty. Keeping the number of authorities fairly small would mean fewer boundaries between them and thus minimise overlapping of services: it would also assist the flow of information, ideas and policies between authorities, and between the authorities and the Ministry.

55. Another important factor affecting both the number of areas, and their shape and size, would be the eventual pattern of areas for local government. There would be advantages in having a hroadly similar pattern, and in dividing the country between Area Boards attention would have to be paid not simply to the nature of the health services and the pattern of those services on the ground hut also to the boundaries of the new local government areas unless these were clearly unsuited to the needs of the health services.

[1] If these bodies were responsible for health services but no other service they might appropriately be called Area Health Boards. In this Green Paper they are simply called "Area Boards."

56. Because of geographical features, population densities and other factors it is likely that the Areas would vary considerahly in size. If there were about forty the average population might be near to one million and a quarter though several Areas might have less than three-quarters of a million and a few as many as 2 or 3 millions.

Membership

57. The members of Area Boards would have the highly responsihle and exacting task of making sound policy decisions to secure the efficient allocation and management of resources, in the light of their knowledge of the needs of the service and of local affairs. Experience of the administration of the existing services has proved the worth of having as members of such authorities persons who are willing to serve in a voluntary capacity and to make these policy decisions. If this were the form of administration for Area Boards, it wonld mean a considerahle reduction in the actual number of persons required to serve, since the present Executive Councils, Hospital Boards, Board of Governors and Hospital Management Committees would all be replaced hy the smaller number of comprehensive authorities. This reduction in numbers, however, would not imply any criticism of the work of the many present voluntary members within their current terms of reference.

58. It is suggested that Area Boards should be small, generally of about fifteen or sixteen members, including the Chairman. This would make for efficient consideration of the important aspects of policy with which members should be concerned. It should also make it the easier to estahlish a clear distinction between the rôle of Board members in directing tbe service and that of officers in running it. The advantages of maintaining this distinction have been pointed out in the context of local government and are applicable to the administration of the health services. The replacement in each area of several Hospital Management Committees hy the single Area Board shonld, as regards hospital management, make this distinction easier to draw.

59. In general, it would be desirahle to provide for flexihility in the size and composition of the membership of Boards, and room should be left for evolution. In order to hring direct experience of the practical prohlems of the services and to assist with the task of remodelling patterns of care, some members with hroad professional knowledge of medical and related services would be needed, though it would not be desirahle for these to be nominated to represent special interests. In areas containing medical schools the Minister might appoint on the nomination of universities one or two additional members. In addition, it would be important to make arrangements to ensure that appropriate account was taken of the interests of local authorities. It is for consideration how this could best be done and this is a matter on which comment would be particularly valuable.

Internal Organisation

60. The Area Board would require a type of internal organisation appropriate to its comprehensive rôle. It would have to be something much more than a roof beneath which separate parts of the service such as the hospitals on the one hand and community services on the other could lead distinct and largely uncoordinated lives. It would also need to prevent any tendency for one element in the service to dominate and distort its policies. With this in mind, its first main task would be to weld together the services as a whole in hoth forward planning and day to day operation. At the outset it would concentrate on securing

better co-ordination between tbe various elements but in time should find that the houndaries between tbem become less distinct and no longer a barrier to the better use of manpower and other resources.

61. To promote integration tbere would be a clean hreak from the present divisions: committees would not for instance be set up to deal witb particular services in tbe area sucb as "bospital services" or "general practitioner services". Any standing committees appointed by the Area Board should cover all parts of tbe service. They sbould be few and should be kept small in the interests of efficiency. A single committee might deal with all the planning and operation of services. This committee would need wider professional participation than would the Board itself. In order to draw on further experience and in particular professional experience, it would be desirable to arrange for the co-option to committees of people not themselves members of the Board. Committees would also be expected to hring in for consultation other professionally qualified persons as necessary when particular professional suhjects were to be considered, either hy the full committee or by a part of it.

62. Tbe principle of promoting integration should similarly be applied in the constitution of any advisory body or bodies which might be established in each area, so that they would be able to advise the Area Board as far as possible on the whole range of services.

63. The organisation of the Area Board's headquarters should also be such as would ensure the comprebensive planning and management of services. The desirahle form of organisation seems to be a functional one. There might be four or five major departments:

(1) Planning and operation of services:—maintenance and development of unified services; planning of new capital projects; research and statistics; and liaison with the services of other authorities.
(2) Staff: personnel and staffing matters; establishments; training; recruitment; careers; and contracts for service—with special emphasis on securing the optimum use of staff throughout the service.
(3) Logistics: supply; construction and maintenance of building and engineering services and equipment; and transport.
(4) Finance: estimates; accounts; costing and cost/effectiveness analysis.
(5) Secretariat: including beadquarters and senior establishment work; management services; and public relations. (Possibly in smaller Areas this could be combined with the Staff Department at (2) above.)

64. The rôle of the headquarters departments is seen as mainly the planning and general direction of services. Each department would be staffed by administrative and professional officers, all responsible to its directing head, who might in some cases be a professional officer and in some cases an administrative officer. The principal criterion for appointment to directing posts would be management ability.

The Executive and Senior Officers

65. With this form of organisation the senior officers of the Area Board appointed as "directors" of the four or five functional departments would together make up a small Executive. This Executive would meet frequently and be collectively responsible to the Board for advising it on its objectives and policies,

for organising the services of the Area, for executing the Board's policies and for maintaining the standard of services.

66. The Chief Administrative Officer would have as his principal task the co-ordination of the work of the directors and he would preside at the meetings of the Executive. He would be the Board's principal adviser on all non-professional matters and would also be director of the secretariat department. It would be for consideration whether in some areas he should combine this with the post of head of the staff department, with suitahle administrative support.

67. The Chief Medical Officer, also with access to the Board, would be its principal adviser on all medical professional matters and would be director of the " Planning and operation of services " department. He would be the profes-sional head of all headquarters medical staff of the Board in the sense that a doctor in any of the Board's headquarters departments would be entitled to refer to him any matter of major professional importance.

68. A member of each profession employed in the headquarters departments would be designated as chief officer of that profession, whom the other members of the profession employed in the departments could consult on matters of major professional importance, and who could put a professional view to the Executive or, in appropriate cases, to the Board itself.

Local Administration

69. No two Area Boards would be likely to be faced with identical problems of internal administration. Within broad guidelines, each would need to develop an organisation suited to its circumstances, and be prepared to adjust this from time to time and to distribute functions to its officers as changing conditions required. It would need to lay down clear lines of responsihility so that, for example, responsible officers at outlying hospitals or clinics would have the advice and control of superior officers whenever this was necessary. Supporting functions such as the provision of supplies, laundry, the maintenance of build-ings and equipment, transport, the payment and recruitment of staff and financial procedures would be carried out in the most efficient way, on an area, district or unit basis.

70. The staff locally in charge should be given as much personal responsibility as practicable. In particular, officers responsible for hospital services at the level of the major individual hospitals and groups of hospitals providing district general services would continue to carry substantial responsibilities.

71. The new comprehensive Boards would he required to develop arrangements for securing integration of the separate services within each of the several operational districts which each Area would contain. The services in each district incorporating health centres and all other facilities as well as a hospital, or several hospitals, providing district general services, would be the basic hricks in each Board's administrative arrangements. Day to day co-ordination of these services would fall upon the senior staff working within them: for example, the chairman of the hospital medical advisory committee or its equivalent, the hospital administrator, the community physician and—though not themselves " staff "—the general practitioners. To assist them there could he assigned to district officers with a general responsihility for helping to co-ordinate services and for keeping the headquarters in touch with local developments.

FRAMEWORK FOR AREA BOARDS

Flexibility

72. The main framework of the new administrative structure would be embodied in legislation but it would be very desirable that so far as possible within this framework there should be flexibility and room for new approaches. This opportunity has been lacking in the pattern of administration under the existing law. The legislation which would be required to set up specially constituted Area Boards might, subject to the decisions of Parliament, have the following aims.

(*a*) The Minister would have a general statutory duty to promote the development of comprehensive health services for the people of England and Wales and for that purpose to provide or to secure the provision of services.

(*b*) The Minister would have a specific statutory duty to provide throughout England and Wales, to such extent as he considers necessary and reasonable, accommodation and services, including hospital and specialist services and community health services. In addition to this requirement to provide services, the Minister woud be required to arrange the provision of certain other community services, including general medical, dental, ophthalmic and pharmaceutical services.

(*c*) For these purposes the Minister would be required to set up Area Boards, to exercise on his behalf functions with respect to the administration, management and control of the services in accordance with regulations and with such directions as might be given by him. It would be a specific statutory duty of the Boards, in accordance with regulations, to make arrangements with medical and dental practitioners, opticians and pharmacists, for the provision of general medical, dental, optical and pharmaceutical services. The responsibilities and powers of Boards and their officers in relation to public health, food hygiene and safety and environmental hygiene would be provided for.

Rôle of the Minister in relation to Area Boards

73. The Minister should not intervene in the detailed management of the services by the Area Boards (although he would have powers to do so as a last resort) since this would detract from the Boards' sense of responsibility and would also leave him less free to concentrate on his own central directing tasks. While the Minister would have a general power to give directions on any aspect of the service, it is suggested that as far as possible he should use these powers, not to settle particular matters, but to lay down general principles. Thus he might define from time to time the matters in which Boards would be required to follow standards of good practice formulated centrally, and perhaps specify certain specialised services the development of which would require his specific approval.

74. Securing the co-ordination of services administered by the separate Area Boards would be a part of the Minister's responsibility and he could when appropriate use his powers to take specific action or ensure that it was taken by the Boards. For example, it would be necessary for groups comprising two or three Boards to make joint arrangements for the discharge of certain of their functions and if need be the Minister would use his powers to bring this about.

The Minister would also be able to provide services direct, where these were more appropriately provided on a national basis.

75. The Minister would on many matters probably prefer to proceed by issuing guidance, e.g. on standards, and it would always be open to Boards to seek it. For this relationship to work well there would need to be a full and steady flow of information and ideas between the Boards and the Ministry, covering all aspects of the service, and there should be opportunities for the exchange of professional and other staff.

76. An important example of existing services which would need to be further developed, partly by joint arrangement of several Area Boards and partly by the Minister direct, would be operational research, and such statistical and related information services as were essential for efficient management by the new Boards and for a proper understanding of their activities.

77. If it were decided to set up Area Boards the appropriate administrative arrangements for the Special Hospitals at Broadmoor, Rampton and Moss Side, which are at present administered directly by the Minister, could be reconsidered.

Dealing with Complaints

78. If Area Boards were set up they would be expected, as the responsible local managers of the services, to deal promptly with complaints from members of the public about the services provided for them or their relatives. When appropriate, as it might well be in serious cases, they would be able to investigate the complaint formally, as the present hospital authorities do, if necessary setting up an independent enquiry for the purpose.

79. There might nevertheless be cases where the member of the public who made a complaint to an Area Board was dissatisfied with their reply or the action taken, and wished to seek an independent view. Alternative ways of approaching this problem could be considered. For instance, if it had been decided to set up Area Boards with comprehensive responsibilities covering the full range of health services to the patient, consideration might be given to bringing the relevant activities of the Boards within the ambit of the Parliamentary Commissioner for Administration in order that he could enquire into matters referred by Members of Parliament within his own terms of reference.

80. An alternative possiblity for consideration is that there should be available a person, not appointed by either the Area Board or the Minister, but perhaps by the Privy Council, who could be asked directly by the complainant to look into the matter locally, and who after due enquiry would report to the Board on whether there was any further action which, in his view, the Board should take. Such an independent person might perhaps on the analogy of the Parliamentary Commissioner for Administration be called a "Health Commissioner". Normally the Board would be expected to accept and implement the Health Commissioner's recommendation, but in the event of this not being done the matter might be reported to the Minister who would then have the responsibility for deciding, after considering the Commissioner's report, what action should be taken. The Minister himself would be answerable to Parliament and arrangements would be needed so that the Commissioner could make known to the public and Parliament cases where his recommendations were not accepted.

81. So that each part of the country was covered by a Health Commissioner familiar with the local circumstances there might need to be more than one. It might be desirable for a national Commissioner to exercise a general oversight of the working of the arrangements and thus to ensure a common standard of practice in the investigation of complaints throughout the country.

82. Many types of personal and individual complaints would be open to investigation by the Health Commissioners. The boundaries of their jurisdiction would however need careful definition. For example they would not intervene in an issue such as an allegation of negligence which could more properly be pursued in the courts, or take up matters between the Board and its employees. The Health Commissioners would not be concerned with clinical matters to a greater degree than an *ad hoc* board of enquiry set up under existing arrangements by a hospital authority or by the Minister; or than the Service Committees which deal with allegations that a general medical or dental practitioner, optician or pharmacist has failed to comply with his terms of service. The Health Commissioner's relationship, if any, with Service Committees would also need to be considered.

Staff and Training

83. Area Boards would be the employing authorities for all their staff. The importance of staffing and personnel matters would be recognised if, as has been suggested above, a "Staff Department" were to be one of the main functional divisions within the organisation of each Board.

84. Rates of pay and conditions of service would continue to be settled through national machinery. Certain aspects of manpower would also have to be centrally supervised. This is because it is essential to secure on the one hand a balanced development of services over the country as a whole and on the other a satisfactory career structure: these must be among the most important of all objectives in the successful management of a national service. In recent years, for example, the balanced development and career structure of specialist medical staffing in hospitals have been dealt with under special arrangements, and this must continue to be so. Arrangements for postgraduate education have been mentioned in paragraph 42.

85. At national level it is also suggested that it might be desirable for a body to be created to carry out for as wide a range of staff as possible functions similar to those now undertaken by the National Staff Committee for administrative and clerical staffs in the hospital service, and by the National Nursing Staff Committee. Its functions would be to improve methods of planning careers, to assist in organising non-professional training, and to develop selection and appointments procedures.

86. In general, the devising and supervision of training programmes would need to be handled on a wider geographical basis than a single area.

87. Steps would also have to be taken well in advance of making any final change to a new administrative structure to prepare staff for their prospective rôles. In particular training for management in a unified service should be an early priority.

88. Before any changes in the administrative structure were implemented, there would be full consultation with all staff interests concerned, on their

effects on the staff themselves, for example on any superannuation questions which might arise. The Government would also consult with the appropriate bodies regarding any consequential changes in the administration of the training of professional staff.

Financial Aspects

89. The services administered by the existing hospital authorities and Executive Councils are financed by the central government and if these were transferred to specially constituted Area Boards responsible to the Minister, this basis of finance would be continued. This would be a straightforward change so far as central government finance is concerned bnt it would be necessary to consider arrangements for the distribution and management of the Hospital Endowment Fund and Trust Funds held by hospital authorities.

90. If Area Boards were set up, it is assumed that the central government would take responsibility for any services transferred to them from the local authorities and that the assets and liabilities of authorities in respect of services transferred would be transferred to the Minister. There would be important financial issues to be considered in such a transfer. Current expenditure on local authority health services is approximately £140 million a year and is increasing. At present it forms part of the relevant expenditure of local authorities taken into account in determining the level of the Rate Support Grant. If the central government were to assume direct financial responsibility for some or all these services it would be necessary to take the changed circumstances fully into account in the financial transactions between central and local government.

91. Part of the present revenue expenditure on the local health services is the servicing of loans raised by local authorities to finance capital works. No compensation would be payable for assets transferred but the central government would assume responsibility for outstanding loans and would provide direct finance for further capital development.

92. At present total expenditure on the health services in England and Wales amounts to approximately £1,400 million a year. It is to be expected that if Area Boards were set up the Government would make financial resources available to them in accordance with their range of functions and requirements and in the light of competing claims, as they do at present in the case of the centrally financed health services. The sums required would be the subject of Estimates presented to Parliament and the Votes would be accounted for in the usual way; the Minister would be answerable to Parliament as he is at present in respect of the centrally financed health services. The accounts of Boards would be audited by auditors appointed by the Minister, and the Comptroller and Auditor General would have access to them and report upon them. Since the Area Boards would be administering services on behalf of the Minister, using central funds, the financial transactions of the Boards would be subject to Regulations made by the Minister (for example, as to general financial control and the setting up by Boards of Finance Committees and the responsibilities of these Committees and of Chief Financial Officers).

93. A transfer to Area Boards of responsibility for administering the various services should not of itself have any very appreciable effect on the level of expenditure on health and welfare services taken as a whole. (A temporary

increase in central government expenditure would, however, be expected from the change in the method of financing capital works mentioned in paragraph 91.)

94. Integration of the services and more efficient use of resources, including staff, should, once the new arrangements had become established, ensure a substantial improvement in the effectiveness with which the finance made available for the services was used. The Minister would have in mind the need to develop services as a balanced and coherent programme, with the community services being given proper scope. Within the limits set by the Minister in such national policies, it would be within the discretion of Area Boards to use the funds allocated to them in accordance with their assessment of local requirements.

Logistics

95. "Logistics" is a term used to indicate a number of the very important activities which would be required to support Area Boards' comprehensive health services. Chief among them would be the provision of buildings, in accordance with the Area's development plans, the supply of equipment and stores, transport and maintenance services. The detailed arrangements for these supporting functions would require careful consideration. As regards the proposals to set up Area Boards the following points should be kept in mind.

96. To provide and equip new premises for the services administered by the Area Boards and to improve and maintain existing buildings, plant and equipment, three main activities would be required:

(*a*) to draw up the capital programmes,
(*b*) to plan, design, construct and commission the new buildings,
(*c*) to maintain what is already in use.

Capital Programming

97. The starting point for the Board's comprehensive capital programme would be the hospital building programme established under the present arrangements, and the long-term plans of local authorities for the development of health centres and other services. Steps for implementing these programmes would already have been planned for several years ahead—e.g. up to ten years in the case of hospital programmes. Within a nationally determined and carefully balanced overall plan, these programmes would be periodically reviewed and rolled forward by the Area Boards, who would decide on the steps for implementing them, in accordance with the resources made available to them for this purpose. In the case of the largest hospital projects, however, where the sums involved were very substantial in relation to a single Board's resources, decisions on priorities would have to be made centrally, since this would involve choosing between very large schemes in different areas, and affect the balance of the programmes as a whole.

Design, Construction and Maintenance

98. Area Boards would be building authorities and would themselves plan, contract for and supervise both the maintenance of existing premises and services and the provision of new buildings, subject to any necessary approval by the Ministry and guidance on standards. For some of this work they would probably commission outside firms of consultants. Boards would be as self-sufficient as possible, but in the case of some large projects the capacity of a single Board's office might be too small to provide suitably skilled project teams. The grouping